APPEAL DECISION LETTER Healthy Way LA
OVERTURN DECISION

Date:

Name: *(Insert Member Name or Representative):*
Member's Name:

Address:
City, State, Zip

Provider/Clinic/CAU:

Dear ***(Insert Member Name or Representative)****:*

A decision has been made about your appeal of ***(describe appeal)****.* The decision was made on (insert decision date).

After careful review and investigation, our reviewer does not agree with the original decision.

Your request has now been approved. Authorization *(insert authorization number)* for **(*insert service*)** is effective from ***(insert effective dates).*** Please call ***(insert provider/clinic name and telephone number)*** to make an appointment for this service.

If you have any questions, please call DMH Patients' Rights at (213) 738-4949.

NOTE: If you cannot read or understand this letter, call Patients' Rights at (213) 738-4949. If you have trouble hearing or speaking, use TTY/TDD at (800) 735-2929.

Sincerely,

_____
(Name of Patients' Rights Advocate)

c: Requesting Provider/Clinic/CAU